



COLUMBIA UNIVERSITY
MEDICAL CENTER

Discover. Educate. Care. Lead.

Registration Form

For office use only

MRN Number _____

Dx. _____

Name _____
 Street Address _____
 City _____ State _____ Zip code _____
 Home Phone Number _____ Daytime Number _____
 Cell Phone _____ Email Address _____
 Date of Birth (mm/dd/yyyy) _____ S.S. # _____
 Sex Male/ Female _____ Marital Status: Single Married Separated Divorced Widowed
 Father's First Name _____ Mother's First Name _____
 Employer _____ Occupation _____
 Employer's Address _____ City, State, Zip _____

Primary Care Physician _____
 Office Phone Number _____ Fax Number _____
 Address _____ City, State, Zip _____

Referring Physician _____
 Office Phone Number _____ Fax Number _____
 Address _____ City, State, Zip _____

Insurance Information

Primary Insurance
 Insurance Company _____
 Name of Policy Holder _____
 Policy number _____ Group Number _____
 Address _____ City, State, Zip _____

Secondary Insurance
 Insurance Company _____
 Name of Policy Holder _____
 Policy number _____ Group Number _____
 Address _____ City, State, Zip _____
 Policy Holder name (If different than patient) _____
 S.S.# _____ Date of Birth (mm/dd/yyyy) _____
 Employer _____

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment or benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature

Relationship

Date



50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

GENERAL PATIENT INFORMATION: (To be completed by Patient, Guardian or Admitting Nurses)

Name: _____

Fluent in English: Yes No Language Spoken: _____ Translator needed: Yes No

Age: _____ Sex: _____ Date of Birth: _____ / _____ / _____

Surgeon Name: _____ Expected Date of Surgery _____ / _____ / _____

Primary Care Physician: _____

Primary Care Physician's Phone No. (_____) _____

Cardiologists Name _____ Phone No.: (_____) _____

Expected Procedure: _____

Home Phone: (_____) _____ Work Phone: (_____) _____ Cell Phone: (_____) _____

Telephone Number to be Reached Prior to Surgery: _____

Best time to call: Afternoon Evening May we leave a message? Yes No

Do you have allergies? Yes No FOOD DRUG LATEX OTHER _____

ALLERGEN	REACTION

LIST PRIOR SURGERY	DATE	LIST ANY COMPLICATIONS

What previous Anesthesia have you had?

General Regional Spinal Epidural Local None Unsure

Please list any complications/problems experienced with anesthesia.

Please list prior Hospitalizations Including Emergency Department visits

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Heart: Do you have or ever had the following:

- 1) Atrial fibrillation or irregular heartbeat?
- 2) High blood pressure or Mitral Valve Prolapse?
- 3) A heart attack, angina, or chest pain?
- 4) A heart murmur, heart failure or heart surgery?
- 5) High cholesterol?
- 6) Chest pain or shortness of breath when climbing a flight of stairs?
- 7) A catheterization of your heart? If so,

Date ___/___/___ Where _____

- 8) A heart stress test? If so,

Date ___/___/___ Where _____

Do you:

- 9) Take antibiotics prior to a surgical procedure or dental work?
 - 10) Do you have a pacemaker or implantable defibrillator (AICD)?
- If yes, manufacturer: (check one)
 Medtronic Guidant St. Jude Biotronik Other

Date ___/___/___ Where _____

Ask your cardiologist to send the most recent pacemaker interrogation to the surgeon and please bring your information card with you on the day of surgery.

- 11) Are you 60 years old or older?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
		EKG	*
		EKG	
		CBC, EKG	*
		CBC, EKG	*
		EKG	*
		CBC, EKG	*
		EKG	
		If yes, contact EP specialist	
		EKG	

Breathing: Do you have or ever had the following:

- 12) Shortness of breath with exertion or swollen ankles?
- 13) A need for more than one pillow or wake up at night short of breath?
- 14) Tuberculosis (TB)?
- 15) Smoked more than 1 pk/day for 20 yrs or 2 pks/day for 10 yrs?
- 16) Smoked in the last year?
- 17) Oxygen at home to help you breathe?
- 18) Severe emphysema, asthma or bronchitis (COPD) that limits your activities?
- 19) Did you ever have an embolus or clot go to your lung?

		CBC, EKG	*
		CBC, EKG	
		CXR	
		CBC, CXR	
		CBC, CXR	*
		EKG, CXR	*

Obstructive Sleep Apnea (OSA):

- 20) Do you have Obstructive Sleep Apnea (OSA)?
- 21) Do you frequently snore loudly, enough to be heard through closed doors?
- 22) Have you been told by others that you gasp, choke, snort, or stop breathing during your sleep?
- 23) Do you have or are you being treated for high blood pressure?
- 24) Do you use a BiPAP or C-PAP machine at home?
 If so, settings: _____

		CBC, EKG, CXR	*
		CBC, EKG	
		CBC, EKG	*
		EKG	
		CBC, CXR	*

* Anesthesia Consult Recommended

CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
 LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP



50705

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Blood Disorders: Do you have or ever had the following:

- 25) Anemia or low blood count?
- 26) Bleeding ulcers or rectal bleeding?
- 27) Sickle cell disease or trait?
- 28) Blood clots in your legs (phlebitis) or Deep Vein Thrombosis (DVT)?

Do you:

- 29) Use warfarin (Coumadin) as a blood thinner?
- 30) Bruise easily and/or have a bleeding problem?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
		CBC	
		CBC	
		CBC, CXR	
		PT/INR	*
		CBC, PT/INR/APTT	

Endocrine/Renal Disorders: Do you have or ever had the following:

- 31) Diabetes?
- 32) Adrenal or thyroid disease or tumor?
- 33) Kidney disease, kidney failure or are you on dialysis?
- 34) Severe hepatitis, jaundice, cirrhosis or liver failure?
- 35) Do you use diuretics (water pills), digoxin (Lanoxin) or steroids (Prednisone)?

		BMP, EKG	
		BMP	
		BMP, EKG, CBC	
		LIV, PT, INR, APPT	
		BMP, EKG.	

Gastrointestinal: Do you have or ever had the following:

- 36) Severe abdominal pain?
- 37) Loss of appetite or unintentional weight loss in the past year?
- 38) Acid reflux?

Neurological/Musculo/Skeletal: Do you have or ever had the following:

- 39) Stroke or seizures?
- 40) Weakness in your arms or legs?
- 41) Head, neck or back injuries?
- 42) Chronic pain?
- 43) "Pins and needles" or loss of sensation in your arms or legs?
- 44) "Collagen disease", Lupus, Rheumatoid arthritis, or Raynaud's disease?

		BMP, EKG, CBC	

Obstetrics

- 45) Are you or do you believe you might be pregnant?
 Last menstrual cycle _____.
- 46) Have you been pregnant in the last 3 months?

		BHCG	
		If yes to (#45 & #46) a blood specimen must be sent < 72 hours of surgery for T & S and T & C	

Cancer: Do you have or ever had the following:

- 47) Cancer and/or received chemotherapy?
- 48) Have you received radiation therapy?
- 49) An axillary lymph node dissection (under arm): Yes No
 Which side: _____

		CBC	
		CXR, EKG, CBC	

* Anesthesia Consult Recommended

CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
 LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Department of Perioperative Services
Preoperative Medical Questionnaire - Assessment Data Form

IF NO PLATE, PRINT NAME, SEX AND MEDICAL RECORD NO.

Anesthesia Related Issues: Have you had:

- 50) Problems with placement of a breathing tube in your windpipe (trachea) for surgery?
- 51) Surgery on your throat, vocal cords or lungs?
- 52) Any bad reactions to anesthesia in you or your relatives?
- 53) A history of Malignant Hyperthermia in you or any of your relatives?
- 54) Do you have trouble opening your mouth or bending your neck forward or backward?
- 55) Are you having Bariatric (weight loss), Vascular or Thoracic Surgery (chest)?

You will see YOUR anesthesiologist on the day of surgery. In addition,

- 56) Do you want to see a screening Anesthesiologist before the day of Surgery?

PATIENT ONLY		CLINICIAN USE ONLY	
No	Yes	Test for "Yes" Answers	Anesthesia Consult *
			*
			*
			*
			*
			*
			*
			*

Communicable Disease: Do you have or ever had the following:

- 57) HERPES AIDS HIV
- 58) Contact within the last month with anyone suspected of having SARS?
- 59) Have you traveled outside of the U.S. in the last month?

If yes, where? _____

Eyes: Do you have or had the following:

- 60) Dry eyes?
- 61) Glaucoma or cataracts?

Behavioral Health

- 62) Have you suffered from anxiety, depression, or a psychiatric disorder? ..

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Blood Transfusion: Do you have or had the following:

- 63) Blood transfusion in the last 3 months?
- 64) A reaction or allergy to a blood transfusion?
- 65) Did you donate blood for this surgery?
- 66) Did a family member donate blood?

		If yes to (#63) a blood specimen must be sent < 72 hours prior to surgery for T&S and T&C	

* Anesthesia Consult Recommended

CBC = CBC plus platelets, BMP = BUN, CL, CO2, CRE, Gluc, K, NA, AnionGAP,
LIV = ALB, ALP, ALT, AST, DBIL, TBIL, TP

Patient/Guardian Signature _____ Date: ___/___/___ Time: _____ AM/PM

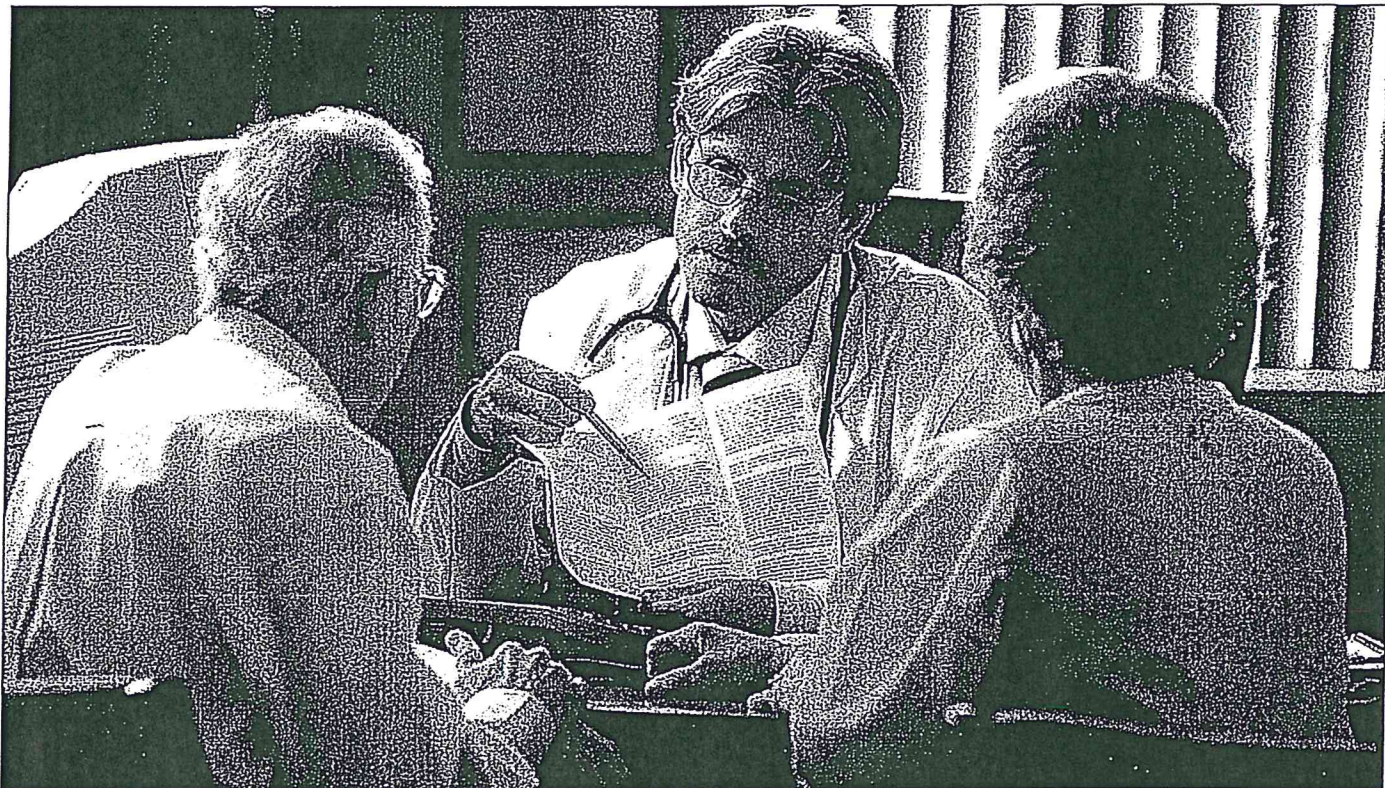
If completed by the RN: _____ RN Date: ___/___/___ Time: _____ AM/PM
Nurses Signature

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.



COLUMBIA UNIVERSITY
MEDICAL CENTER



About this notice

This Notice will tell you about the ways we may use and disclose health information that identifies you ("Health Information"). We also describe your rights and certain obligations we have regarding the use and disclosure of Health Information. We are required by law to maintain the privacy of Health Information that identifies you; give you this Notice of our legal duties and privacy practices with respect to your Health Information; and follow the terms of our Notice that are currently in effect. This Notice covers the faculty physician practices of Columbia University Medical Center ("Columbia University", "Columbia", "we" or "us"), including its employed faculty physicians and faculty physicians practicing on Columbia University owned or leased space, as well as their clinical support staff. This Notice also covers Columbia University Health Care, Inc.; the Ophthalmology Faculty Practice Corporation; Orthopedics, P.C.; Neurosurgery, P.C.; and Urology, P.C. (all "Columbia University"). If Columbia physicians or health care professionals provide you with treatment or services at another location, for example New York Presbyterian Hospital, the Notice of Privacy Practices you receive at such other location will apply.

How we may use and disclose health information about you

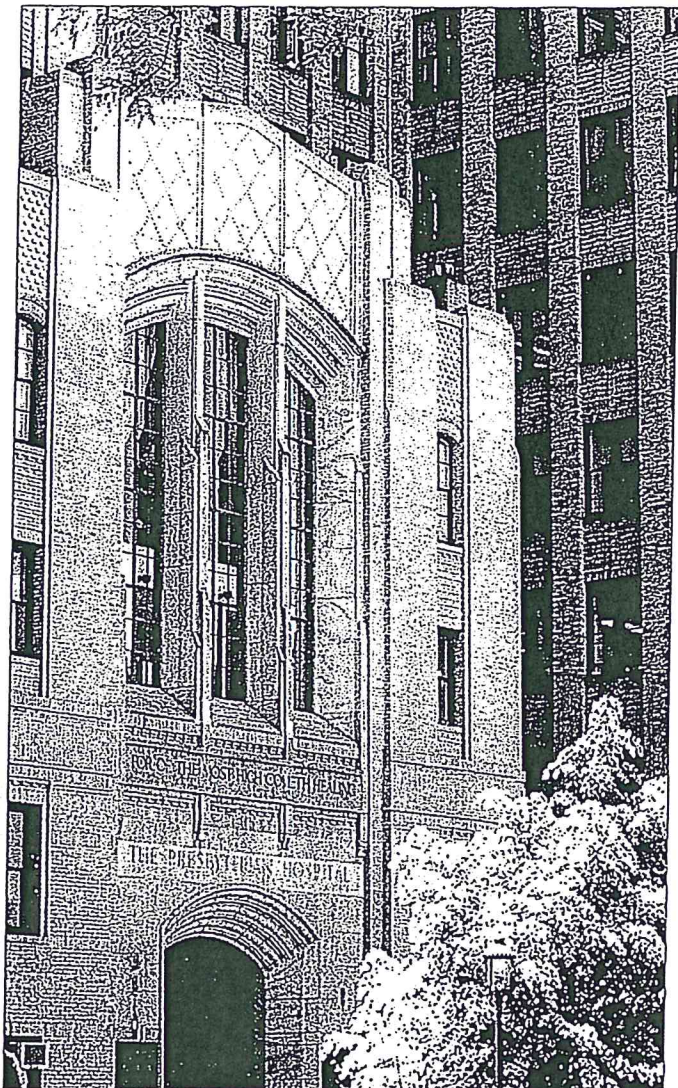
The following categories describe different ways that we may use and disclose Health Information.

For Treatment

We may use Health Information about you to provide you with medical treatment or services. We may disclose Health Information to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, a doctor treating you for a broken leg may need to know if you have diabetes, because diabetes may slow the healing process. Different departments of Columbia University also may share Health Information such as prescriptions, lab work and x-rays to coordinate your treatment. We also may disclose Health Information to people outside Columbia University who may be involved in your medical care.

For Payment

We may use and disclose Health Information so that we may bill for treatment and services you receive at Columbia University and can collect payment from you, an insurance company or another third party. For example, we may need



Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services

We may use and disclose Health Information to contact you to remind you that you have an appointment for treatment or medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Fundraising Activities

We may use your demographic information to contact you in an effort to raise money for Columbia. Any fundraising letter you receive from us will provide you with instructions on how to opt out of any future fundraising letters. We will not use your diagnosis to fundraise unless you authorize us to do so in writing.

Individuals Involved in Your Care or Payment for Your Care

We may release Health Information to a person who is involved in your medical care or helps pay for your care, such as a family member or friend. We also may notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.

Research

Under certain circumstances, we may use and disclose Health Information for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. Before we use or disclose Health Information for research, however, the project will go through a special approval process. This process evaluates a proposed research project and its use of Health Information to balance the benefits of research with the need for privacy of Health Information. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for similar purposes, so long as they do not remove or take a copy of any Health Information.

As Required by Law

We will disclose medical information about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety

We may use and disclose Health Information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, will be to someone who may be able to help prevent the threat.

Business Associates

We may disclose Health Information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to

to give your health plan information about your treatment in order for your health plan to pay for such treatment. We also may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment. In the event a bill is overdue we may need to give Health Information to a collection agency as necessary to help collect the bill or may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations

We may use and disclose Health Information for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and for our operation and management purposes. For example, we may use Health Information to review the treatment and services you receive to check on the performance of our staff in caring for you. We also may disclose information to doctors, nurses, technicians, medical students, and other personnel for educational and learning purposes. The entities and individuals covered by this Notice also may share information with each other for purposes of our joint health care operations.

perform billing services on our behalf. All of our business associates are obligated, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Organ and Tissue Donation

If you are an organ or tissue donor, we may release Health Information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary, to facilitate organ or tissue donation and transplantation.

Military and Veterans

If you are a member of the armed forces, we may release Health Information as required by military command authorities. We also may release Health Information to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation

We may release Health Information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks

We may disclose Health Information for public health activities. These activities generally include disclosures to: a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; prevent or control disease, injury or disability; report births and deaths; report child abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make such disclosure.

Health Oversight Activities

We may disclose Health Information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose Health Information in response to a court or administrative order. We also may disclose Health Information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement

We may release Health Information if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; limited information to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities and Protective Services

We may release Health Information to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law. We also may disclose Health Information to authorized federal officials so they may conduct special investigations and provide protection to the President, other authorized persons and foreign heads of state.

Coroners, Medical Examiners and Funeral Directors

We may release Health Information to a coroner, medical examiner or funeral director so that they can carry out their duties.

Inmates

If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release Health Information to the correctional institution or law enforcement official. This release would be if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

How to Learn About Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse information, mental health information, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these types of information. If your treatment involves this information, you may contact the Privacy Officer for more information about the protections.

Other Uses of Health Information

Other uses and disclosures of Health Information not covered by this Notice or the laws that apply to us will be made only with your written permission. You may revoke your permission at any time by submitting a written request to our Privacy Officer, except to the extent that we acted in reliance on your permission.

Your Rights Regarding Health Information About You

You have the following rights, subject to certain limitations, regarding Health Information we maintain about you:

Right to Inspect and Copy

You have the right to inspect and copy Health Information that may be used to make decisions about your care or payment for your care. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request.

Right to Request Amendments

If you feel that Health Information we have is incorrect or incomplete, you may ask us to amend the information and you must tell us the reason for your request. You have the right to request an amendment for as long as the information is kept by or for Columbia. A request for amendments must be submitted, in writing, to the Privacy Officer at the address provided at the end of this notice.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures" of Health Information. This is a list of certain disclosures we made of Health Information. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list.

Right to Request Restrictions

You have the right to request a restriction or limitation on the Health Information we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the Health Information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Request Confidential Communications

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You may obtain a copy of this Notice at our web site, <http://www.cumc.columbia.edu/hipaa/>.

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the end of this Notice. Alternatively, to exercise your right to inspect and copy Health Information, you may contact your physician's office directly. To obtain a paper copy of our Notice, contact our Privacy Officer by phone or mail.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for Health Information we already have as well as any information we receive in the future. We will post a copy of the current Notice at each Columbia physician office or outpatient location and on our website. The end of our Notice will contain the Notice's effective date.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with Columbia or with the Secretary of the Department of Health and Human Services. To file a complaint with Columbia, contact our Privacy Officer at the address listed at the end of this notice. You will not be penalized for filing a complaint.



COLUMBIA UNIVERSITY MEDICAL CENTER

Questions

If you have a question about this Privacy Notice, please contact:

Privacy Officer

Office for HIPAA Compliance

Columbia University Medical Center

601 West 168th Street

Apartment 22

New York, NY 10032

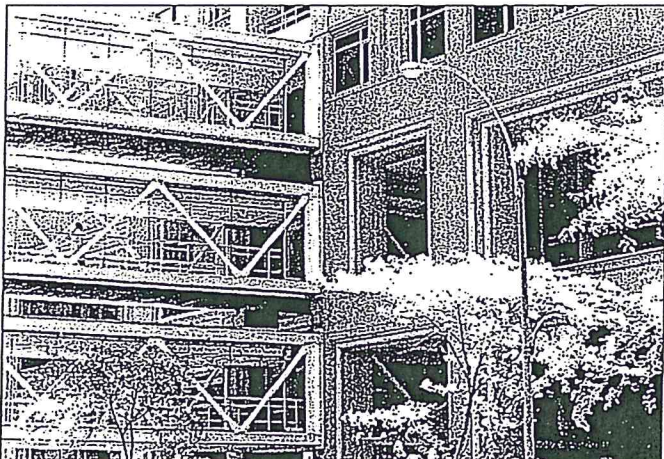
Phone: 212-305-7315

E-mail: hipaa@columbia.edu

Website: www.cumc.columbia.edu/hipaa

Effective date: April 14, 2003

Revised date: October 22, 2007





**COLUMBIA UNIVERSITY
MEDICAL CENTER**

Health Insurance Portability and Accountability Act (HIPAA)
HIPAA Compliance/Columbia University Medical Center
601 West 168th Street, Apt. #22, 2nd Floor
New York, NY 10032/ T(212) 342-0059 F(212)342-5173
<http://www.cumc.columbia.edu/hipaa/>

NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT OF RECEIPT

DATE: _____

I acknowledge that I was provided with a copy of the Columbia University Medical Center Notice of Privacy Practices.

Patient Name (Print)

Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below

Personal Representative (Print)

Personal Representative's Signature

Relationship

For Columbia University Medical Center use only.

Complete this section if this form is not signed and dated by the patient or patient's representative.

I have made a good faith effort to obtain a written acknowledgement of receipt of Columbia University Medical Center's Notice of Privacy Practices but was unable to for the following reason:

- Patient refused to sign
- Patient unable to sign
- Other _____

Employee Name

Date

This form should be placed in the patient's medical record



Patient Questionnaire

Patient Name _____

	Yes	No	Don't Know
Do you get chest pain or angina?	_____	_____	_____
Have you ever had a heart attack?	_____	_____	_____
Have you ever had heart surgery?	_____	_____	_____
Have you ever had heart failure?	_____	_____	_____
Do you have atrial fibrillation or another abnormal heart rhythm?	_____	_____	_____
Is your blood pressure higher than 160/90, even on blood pressure medication?	_____	_____	_____
Do you have a bleeding disorder?	_____	_____	_____
Have you had an asthma attack or wheezing within the last month?	_____	_____	_____
Do you have emphysema or chronic bronchitis?	_____	_____	_____
Do you use a machine at home to help you breath?	_____	_____	_____
As far as you know, has anyone ever had trouble placing a breathing tube in you for surgery?	_____	_____	_____
Have you had surgery in your throat, vocal cords or lungs?	_____	_____	_____
Do you have trouble opening your mouth, or bending your neck forward and backward?	_____	_____	_____
Are you on dialysis?	_____	_____	_____
Do you have cirrhosis of the liver?	_____	_____	_____
Have you ever had an allergic or life-threatening reaction to anesthetics?	_____	_____	_____
Do you know any relative who have had Malignant Hyperthermia?	_____	_____	_____
Do you want to see an anesthesiologist before the day of surgery?	_____	_____	_____

If any box is marked "yes", please refer to the PAU. If all answers are marked either "no" or "don't know", patient may be seen on the day of surgery.

FINANCIAL POLICY

You have been scheduled to see a vascular surgeon. Please note that this visit may be billed by two separate entities. If the surgeon participates with your insurance, the insurance company will be billed by the vascular surgeon who performs your physical exam and the vascular surgeon who reads your report for testing – note that they may not be one and the same. If the surgeon does not participate with your insurance company then you will be responsible for payment in full.

The staff in the Division of Vascular Surgery will help you in any way we can to make sure your insurance plan reimburses appropriately for all covered services and at the correct level of reimbursement. It is important to remember, however, that your health benefits are determined by your employer, your insurance company, and you. Any requirements for pre-authorization, referrals, and/or limitations of coverage are also determined by individuals and companies other than your physicians.

We agree to accept responsibility to provide you with any and all medical care that we deem to be medically necessary for your well-being. You agree to accept financial responsibility for co-payments, deductibles, and any medical care for which you have given consent, although they may not be covered by your health benefit plan. Furthermore, you agree to accept responsibility for understanding the benefits provided by your health plan as well as the regulations regarding pre-authorization and referrals. If medical care is rendered without the appropriate pre-requisites or based on the wrong insurance plan because of inaccurate information provided by you at the time of visit, you agree to assume financial responsibility for those services denied.

This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including any provision regarding grievance procedures that may be available to you.

Patient's Printed Name: _____

Patient's Signature: _____ Date: ____/____/____

Lawrence Hospital Center
CENTER FOR SURGERY
5 WEST

55 Palmer Avenue
Bronxville, NY 10708
(914) 787-4000

Easy Access to Lawrence Hospital Center

Located in Bronxville in Lower Westchester County, Lawrence Hospital Center is convenient to many main thoroughfares.

Area Bridges

- **George Washington Bridge:** Follow signs for Henry Hudson Parkway North, which becomes the Saw Mill River Parkway North. See directions for Saw Mill North.
- **Throgs Neck Bridge:** Take I-95 North to Hutchinson River Parkway North. See directions for the Hutchinson North.
- **Whitestone Bridge:** Follow signs for Hutchinson River Parkway North. See directions for the Hutchinson North.
- **Tappan Zee Bridge:** Follow signs onto the NY Thruway South. See directions for the Thruway South.
- **Tri-Borough Bridge:** Follow signs for Major Deegan North, which becomes the NY Thruway. See directions for the Thruway North.

Major Thoroughfares and Parkways

From the North

- **New York Thruway South:** Get off at Exit 7A, Saw Mill River Parkway South. See directions for the Saw Mill.
- **Hutchinson River Parkway South:** Take Hutchinson to Exit 13, Cross County Parkway. Continue on the Cross County to Exit 6N, Bronx River Parkway North. See directions for Bronx River.
- **Saw Mill River Parkway South:** Get off at Exit 5A, Palmer Road. Turn right onto Palmer. At the 5th traffic light Hospital will be on your left.
- **Bronx River Parkway South:** Exit at Desmond Avenue. Turn right off exit, then right again at Stop sign. Follow blue "H" signs to the Hospital.

From the South

- **Hutchinson River Parkway North:** Take Hutchinson to Exit 13, Cross County Parkway. Continue on the Cross County to Exit 6N, Bronx River Parkway North. See directions for Bronx River.
- **New York Thruway North:** Get off at Exit 5, Central Park Avenue, Rt. 100 North. Stay in right lane to 1st exit, Palmer Road. Turn right onto Palmer and go to 2nd traffic light. Hospital is on your left.
- **Saw Mill River Parkway North:** Get off at Exit 5A, Palmer Road. Turn right onto Palmer. At the 5th traffic light Hospital will be on your left.
- **Bronx River Parkway North:** Stay in right lane; Sprain Brook Parkway veers to left and Bronx River Parkway veers to right. Take the 1st exit, Paxton Avenue. Turn left off exit and right at light. Hospital is on your left. **ALTERNATE:** Take the 2nd exit, Pondfield Road West. Hospital main entrance is 100 ft. on your right.

From the East

- Cross County Parkway West: Take Exit 6N onto Bronx River Parkway North. See directions for Bronx River Parkway.

From the West

- Cross County Parkway East: Follow signs for Bronx River Parkway North. See directions for Bronx River Parkway.

Local Roads

From the North

- White Plains Road (Rt. 22) South: Pass Concordia College on your right. Turn Right at 2nd signal onto Pondfield Road. Continue thru business district, under overpass to rotary. Bear right to Pondfield Road West. Hospital main entrance is on left.

From the South.

- White Plains Road (Rt. 22) North: Turn left at Pondfield Road. Continue on Pondfield thru Bronxville business district. Go under railroad overpass..At rotary, bear right to Pondfield Road West. Hospital main entrance is on left.

Mass Transit

By Bus:

- The hospital is serviced by three Westchester County Bee Line Buses: Numbers 26, 30 and 52. For schedules call 914-682-2020 or check the Bee Line website at <http://www.westchestergov.com>

By Train:

- The Metro North Railroad, Harlem Line services Bronxville. The station is within easy walking distance of the hospital. For the schedule call 1-800-METRO-INFO or check the Metro North website at <http://www.mta.nyc.ny.us>

Parking

- Parking is available in the Hospital's on-site garage or metered parking on the street.